

## Commonwealth of Massachusetts Department of Public Health, Bureau of Health Professions Licensure Drug Control Program

239 Causeway Street, Suite 500, Boston, MA 02114 Telephone 617-973-0949 Fax 617-753-8233

## Amended Information Application for Massachusetts Controlled Substances Registration for

## **Advanced Practice Registered Nurses and Physician Assistants**

(In Accordance with the Controlled Substances Act, M.G.L. Chapter 94C)

No fee is charged when submitting this amended application form. Please be sure to:

- Complete information on both sides of this form. Sign (not initial) and date form.
- Have the supervising physician sign (not initial) and date this form if adding or amending his/her information.
- Include photocopies of your current supervising physician(s)' Massachusetts Controlled Substances Registration and federal DEA Controlled Substance Registration Certificate if adding or amending that information. Where photocopied licenses and registrations are to be submitted, do not send originals. They will not be returned.

## **Amended Information Application**

Please fill out this form in its entirety. Place a check in the box to the left column to indicate information that is being amended.

Amended	In the boxes below enter the reque	sted information.			
	1) Classification: (Select one)				
	○ CNP/NP ○ CNM	I/NM O PCNS/PC	O CRNA/NA O PA		
	2) Massachusetts Board of Registration License No.:				
	DEA Controlled Substance Reg	istration No. (If possess	ed):		
	4) Name:				
	First:	Middle:	Last:		
	Suffix: (e.g. Jr., Sr., II, III)				
	5) Applicant Business Address: Amended applications that include a P.O. Box number without a street address cannot be processed. Out-of-state addresses require a letter of explanation. List every business location where you practice. If you change business addresses during the year, you are required to notify this program by submitting an Amended Application Information form.				
_	Facility Name and Department (if applicable):				
	Street:				
	City:	State:	ZIP:		
	) Applicant Mailing Address:  Facility Name and Department (if applicable):				
	Street:	t (ii applicable).			
	City:	State:	ZIP:		
	7) Business Telephone No.: (	)			
	8) Social Security No.: (Required	by M.G.L. c. 30A, s. 13A	<b>A)</b>		
	9) <b>Drug Schedules</b> requested: Select all that apply: II III IV V VI Schedule VI includes all prescription drugs not in Schedules II - V. Only Schedules that are checked can be authorized.				
	10) E-mail Address:				
	11) Have you ever been convicted distribution or dispensing of co		e or Federal law relating to the		
	12) Has any previous professional entity been surrendered, revol			corporate name or legal  Yes * No	

* If you answered "Yes" to Question No. 11) or No. 12), a letter m	ust be attached setting forth circumstances of such action(s).				
A . P					
Applicant name:	_				
Check here if adding a new supervising physician.					
Check here if amending any of the current supervising physician's information.					
If <b>not</b> adding or amending Supervising Physician's Information, <b>do not</b> enter information in question 13)					
Do not forget to sign and date the application at the bottom of this	page.				
Added or Amended Supervising Physician's Information					
13) The following Supervising Physician's Information must be constructed. The supervising physician is the individual with who agreed upon prescriptive guidelines. you must complete this agreed upon prescriptive guidelines in each setting. You may	m you, the applicant, have developed and signed mutually section for each physician that you have signed mutually make photocopies of this page as necessary.				
Name of Supervising Physician:	Telephone No. ( ) area code				
Business Address:					
Board of Medicine License No.:	Massachusetts Controlled Substances Registration No.:				
DEA Controlled Substance Registration No.:	Medical Specialty:				
	Are there written prescriptive guidelines in place?				
Are there written prescriptive guidelines in place? ☐ Yes ☐ No	D □ N/A (Certified Nurse Midwives only)				
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